Virginia Medicaid Managed Care Annual Report 2011

A year of broadening the reach and constructive impact of Medicaid managed care

Table of Contents

Welcome from the Director

Have you ever heard the word Cairn? – a Cairn (*rhymes with barn and pictured below)* is a man-made pile of stones, often used in places where the direction of a path is not obvious to a hiker. Similarly, coastal cairns are used as beacons to aid with navigation.

If you are like most people, you look for certain "Cairns" to help you navigate through the health care system. A case manager, a member handbook, a health insurance card with toll-free numbers, or even your primary care doctor who may have helped guide you toward timely access to quality care.

Virginia's Medicaid Managed Care delivery system has been carefully designed and built to take the guess-work out of navigating through the complexities of health care. By the end of 2012, nearly all Virginia Medicaid members – from the coast to the mountains - will receive their health care through the managed care delivery system. We have been very busy in 2011 to build this expansion with care.

Throughout this report, we provide evidence that DMAS is getting closer to achieving its managed care goal of *providing a cost-effective managed care delivery system for eligible Medicaid and CHIP members that far exceeds the industry standards for timeliness, access, and quality care.* Read on to find out what occurred in 2011 to broaden the reach and constructive impact of Medicaid managed care.

Wishing you a healthy 2012,

Cynthia B. Jones

Director, Virginia Department of Medical Assistance Services

Expansion

- A groundswell of preparation took place in 2011 to ensure a seamless transition into managed care for most Medicaid/CHIP fee-for-service members in the Roanoke/Alleghany region of Virginia, effective January 1, 2012.
- The expansion increases consumer choice from the previous one MCO in Roanoke/Alleghany to a total of six MCOs.
- Nearly 75% of the estimated 30,000 Medicaid enrollees in Roanoke/Alleghany will be pre-assigned to one of six managed care organizations and will be able to use their managed care benefits beginning January 1, 2012.
- Providers responded very favorably to the change in delivery systems and network development was rapid and met federal and state standards.

Care Coordination

- An authorization process for children's community mental health rehabilitative services was implemented to prevent over and under utilization.
- Foster care children in Richmond City with Medicaid, began participating in a pilot project to receive their health care through managed care, rather than fee-for-service.
- Managed care organizations and early intervention programs enhanced their coordinating efforts for families with very young children who have developmental delays to access quality care.

Quality

- The five existing Virginia Medicaid/CHIP MCOs are accredited by the National Committee for Quality Assurance and ranked in the Top 50 nationally for 2011.
- Virginia Medicaid has established milestones for the newly formed MCO, MajestaCare, to reach in order to be NCQA accredited within two years of the MCO's commencement date.
- Consumer satisfaction surveys show that managed care members are more satisfied with their health care and health plan than those who are served through fee-for-service.
- The collaborative approach to quality improvement between DMAS and the MCOs enables barrier analysis and sharing of promising practices.
- All Virginia Medicaid/CHIP MCOs demonstrated high quality when assessed by an External Quality Review Organization through performance measure validations; performance improvement project validations; and comprehensive onsite reviews.

Guided by Value

Virginia celebrates having all five Medicaid MCOs ranked nationally in the Top 50 by NCQA. These rankings are just one key attribute of this effective delivery system, which benefits the Commonwealth in many ways:

Financial stability – Medicaid MCOs conduct business at full risk and are paid a capitation rate to cover all administrative and medical services for the member and program. If the cost of care exceeds the paid rate, the MCO is liable, not Virginia Medicaid.

Member benefits – Medicaid members receive many health care benefits through MCOs that are above and beyond the benefits received by those in fee-for-service, for example: health education, provider access, 24/7 call center, chronic care management, enhanced maternity and child program, enhanced provider network, and ultimately, improved health outcomes.

Provider networks – MCOs have specific business areas to manage, recruit, contract, monitor, and credential providers for network stability and quality outcomes. MCOs are uniquely positioned to develop variable payment mechanisms, including incentives for providing quality care.

Program flexibility – MCOs are encouraged to be innovative and add new programs to meet the health care needs of the members and administrative challenges of the providers. The Centers for Medicare & Medicaid Services (CMS) routinely excludes the MCOs from burdensome policies and procedures that drive States' fee-for-service delivery systems. This flexibility enables the plans to design and continuously improve their own programs – both efficiently and effectively.

Utilization review management – MCOs have strong clinical teams who develop protocols, review variances, and develop programs to control both over and under utilization of health care services. This allows for ease in forecasting utilization trends and identifying opportunities for both clinical and administrative improvements.

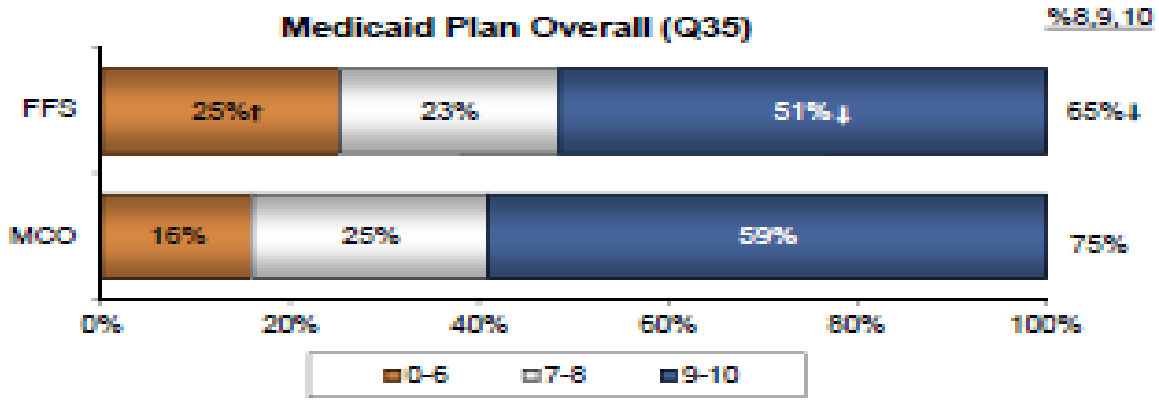
Collaboratives - The plans collaborate with each other and DMAS in operational, quality, and program integrity initiatives.

CAHPS® 4.0H Adult Medicaid Survey

In 2010, the Delmarva Foundation for Medical Care, Inc. (DFMC) commissioned WB&A Market Research to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 4.0H Adult Medicaid Survey on behalf of the Commonwealth of Virginia Department of Medical Assistance Services. The CAHPS® program is funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ), and is an industry standard for assessing customer satisfaction for health care delivery.

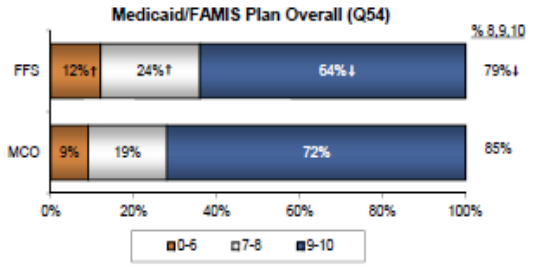
The CAHPS survey was administered to adult members enrolled in the Virginia Medicaid Fee-for-Service (FFS) delivery system. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Members were asked to give their overall ratings of their Doctors, Health Care and Medicaid Plan using a "0 to 10" scale, where a "0" means the worst possible rating and a "10" means the best possible rating. Within the report, comparisons to the survey conducted among Virginia Medicaid's MCO members were present.

A key finding when comparing FFS and MCO responses to questions of satisfaction with their health plan, FFS members gave lower satisfaction ratings for their Medicaid Plan overall (65%, significantly lower than 75% among MCO members).

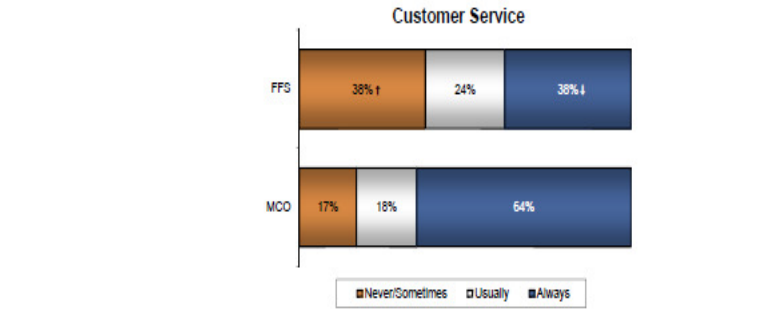


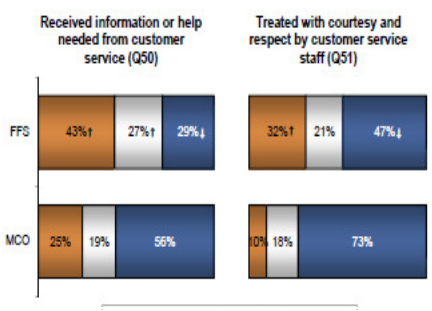
CAHPS® 4.0H Child Medicaid Survey

Similar to the adult survey, in 2010, DFMC commissioned WB&A to conduct the CAHPS® 4.0H Child Medicaid Survey with Children with Chronic Conditions (CCC) Measurement Set on behalf of DMAS. This survey was administered to parents/ guardians of child members 17 years of age and younger who were enrolled in the Virginia Medicaid Fee-for-Service (FFS) delivery system. Within the study the "General Population" refers to children with Medicaid (with inclusion of the CHIP population). The results of the FFS survey compared less favorably to the higher level of satisfaction among the parents of Medicaid/CHIP children who received care through an MCO.



Children with Chronic Conditions

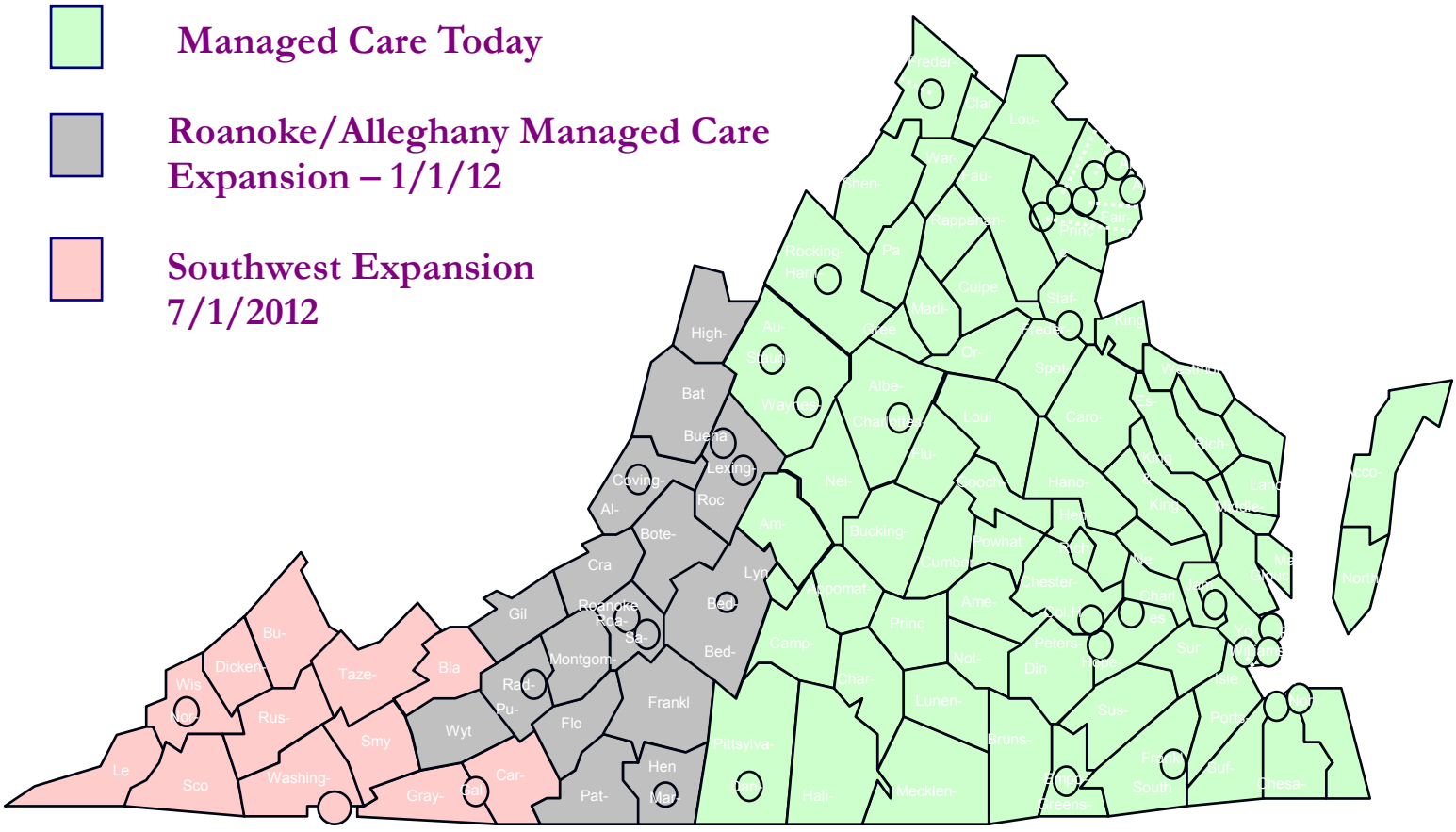




The survey asked an additional set of questions for children with a chronic condition. Consistent with the findings from the child survey for the general population, the parents of children with a chronic condition were least favorable for those in fee-for-service Medicaid/ CHIP when compared to managed care.

Expanding Medicaid Managed Care *West*

DMAS and all of the health plans worked diligently in 2011 to set the stage for expanding Medicaid managed care westward. The expansion will result in a shift from 60% to 75% of Medicaid members being served through managed care by the end of 2012. Additionally, consumer choice of health plans is increasing. When the Roanoke/Alleghany expansion becomes effective in January 2012, eligible members will be able to choose from a list of six MCOs, rather than the current one. The choices of MCOs for serving the southwest expansion, effective July 2012 will be announced well in the spring.



New authorization requirement

Effective July 2011, DMAS began requiring an independent clinical assessment as a part of the service authorization process for Medicaid and FAMIS children's community mental health rehabilitative services (CMHRS). The eligible population includes children and youth up to age 21 enrolled in Medicaid and FAMIS fee for service or managed care programs. DMAS is contracting with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) (herein referred to as the "independent assessor") to conduct the independent clinical assessment. The affected children's community based mental health rehabilitative services are Intensive In-Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Support Services (MHSS). Each child or youth must have at least one independent clinical assessment—either prior to the initiation of the affected services mentioned above or for individuals already receiving services, the independent clinical assessment will be required as part of the first service re-authorization process. Children and youth who are being discharged from residential treatment do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required, however, to have an independent clinical assessment as part of any subsequent service reauthorization.

Independent assessors must meet the DMAS definition of a licensed mental health professional including persons who have registered with the appropriate licensing board and are working toward licensure. The assessments serve as a bridge from unmet mental health needs to treatment.

The structural change to receiving authorization through an independent assessment enables timely access to quality mental health services for eligible children and youth as it is specifically designed to prevent both over **and** under utilization of these critical services.

It is common for a child entering foster care to have a significant amount of unmet health care needs. It is critical for the short and long-term well-being of children in foster care that they experience care that is patient-centered and well-coordinated. This care coordination does not exist in the fee-for-service delivery system, which, historically, has been the only health care delivery model for Virginia's children in foster care.

In 2011, the General Assembly formally endorsed a pilot project with the City of Richmond Department of Social Services to meet the health care needs of children in foster care through the managed care delivery system. Item 297 MMMM1.b. of the 2011 Appropriations Act required the Department to

> *……. allow on a pilot basis, foster care children, under the custody of the City of Richmond Department of Social Services, to be enrolled in Medicaid managed care (Medallion II).*

DMAS staff from various divisions have been working collaboratively with the Richmond Department of Social Services (RDSS) and four of the Medicaid contracted MCOs since 2010 to plan and implement the pilot project. This group of key stakeholders achieved the following milestones in 2011 in order to implement the Richmond City pilot project by the end of the year:

- Agreement that managed care will provide the most coordinated care system for the children in foster care;
- Agreement to implement a coordinated care system that allows for open communication between the MCO case managers and the RDSS social workers; and, between MCOs when a child in foster care changes from one MCO to another;
- Identification of the types of services to be covered and the populations excluded;
- Development of a robust training plan that will equip key care coordination representatives—including foster care parents—with the knowledge to access and fully utilize the health benefits delivered through managed care; and,
- Approximately 200 children were determined eligible for the pilot project. An evaluation of the pilot will determine if this delivery system is the best way to provide care to foster children in foster care throughout the state.

Early Intervention (EI) services are designed to meet the treatment needs of an infant or toddler up to age 3 with developmental delay in one or more areas of development - physical, cognitive, communication, social or emotional, or adaptive. Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can be the child's home or a community based setting in which children without disabilities participate. EI services are designed to address the developmental needs of the child and build the capacity of families to enable the child to experience family centered treatment.

EI services for children who are enrolled in a contracted MCO are covered by the Department (not the MCO) within the Department's coverage criteria and guidelines described in 12 VAC 30-50-131. The services are to be administered in compliance with Federal Part C payor of last resort requirements.

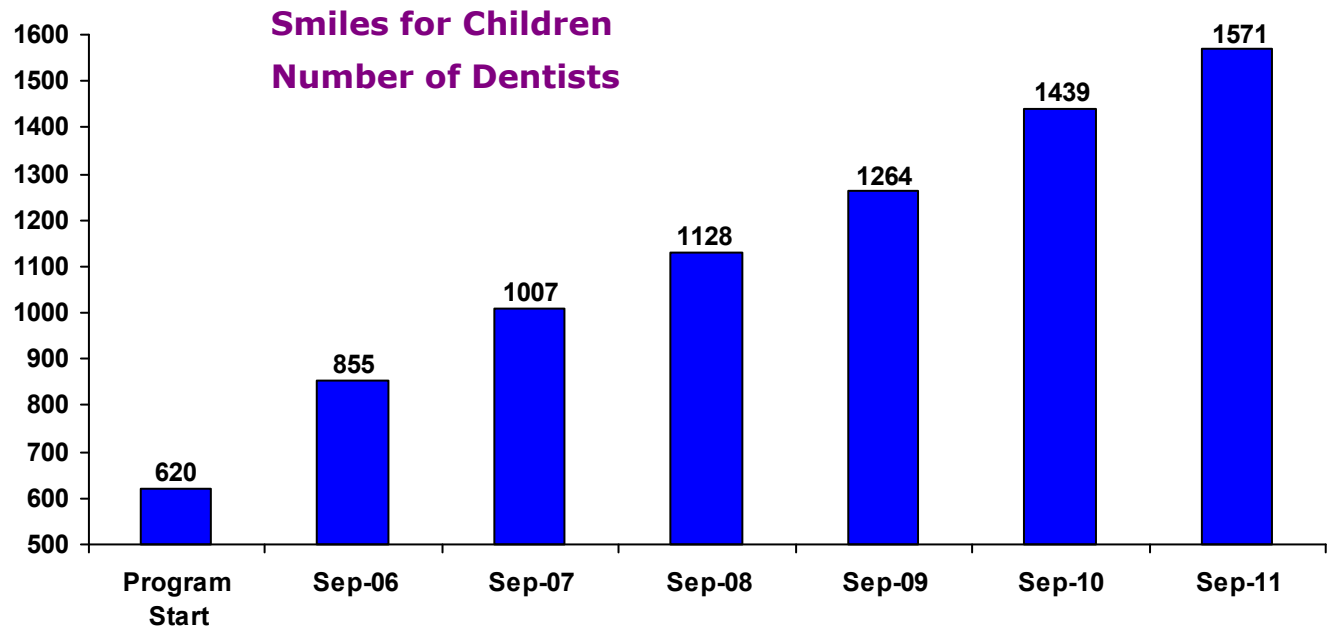
The MCOs are required by DMAS to cover other medically necessary services, including, but not limited to well-child visits, immunizations and rehabilitative/ developmental therapies that fall within EPSDT guidelines.

The exceptional coordinated team approach to EI enables developmental delays to be identified at an early stage, when treatment is most feasible and effective. Even further, with EI, a child's capacity to learn, be active, and socialize can soar beyond expectations and serve as a springboard for a successful experience in a school setting.

The mouth reflects general health and wellbeing. The mouth is a readily accessible and visible part of the body and provides health care providers and individuals with a window on their general health status. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000

Dental services are a mandatory Medicaid benefit for children. Section 1902(a)(43) of the Social Security Act specifically requires the State Medicaid plan to provide or arrange for such services. In addition, the Virginia State Plan for FAMIS, as provided for in the *Code of Virginia* § 32.1-320, as amended, includes provisions for dental benefit coverage for FAMIS children. Dental services also are provided for members enrolled in certain waiver programs.

Dentists assess a child's health from a perspective that is unmatched by any other health professional and, often times, the dentist may be the catalyst for families to make disease prevention and early detection a habit for life. DMAS' 2011 goal was to have a total of 1,400 providers in the ***Smiles For Children*** network. Currently at 1,571 providers (August 2011), the network has experienced a 153% increase since the program started. The chart below shows the continued upward trend.



Comprehensive Operational Systems Review

Federal Regulations provide specific requirements for Medicaid managed care quality, which must be operationalized within each MCO for the delivery of quality care. It is imperative for an MCO to comply with Federal requirements and operationalize them for the good of the populations served. The comprehensive operational systems review is conducted once every three years by the EQRO and is designed to determine the level of compliance by each MCO with Federal regulations—42 CFR Parts 400, 430, et al. The protocol efficiently combines the use of two main sources of information to determine compliance—document review and interviews with MCO staff. This dual approach enables the EQRO to determine the extent to which each MCO complies with the BBA regulatory provisions. All five MCOs performed well.

Though not required by the BBA, a modified onsite OSR will occur in 2012 .

Performance Improvement Project (PIP) Validation

As a purchaser of health care for nearly one million Virginians, DMAS wants to be confident that quality improvement methods reported by the MCO's are real. Each year DMAS commissions the EQRO to validate two PIPs per MCO. While this was the fifth and final year for the PIPs topics of childhood immunizations and well-child visits, MCOs will continue to be held accountable for effectively delivering these important preventive services. All five MCOs performed well.

Look for new topics in 2012!

Performance Measure Validation

Transparency and public reporting are important to consumers. When an MCOs performance is publicly reported, it must be accurate. Each year, DMAS selects two performance measures for validation by the EQRO. The validation process is in-depth and conducted onsite in order to review the data collection processes—including IT systems and paper-based information. This is the third and final year of validating the performance measures for childhood immunizations and cholesterol screening for people with cardiovascular disease– both of which were HEDIS measures. All five MCOs performed well.

Look for new topics in 2012!

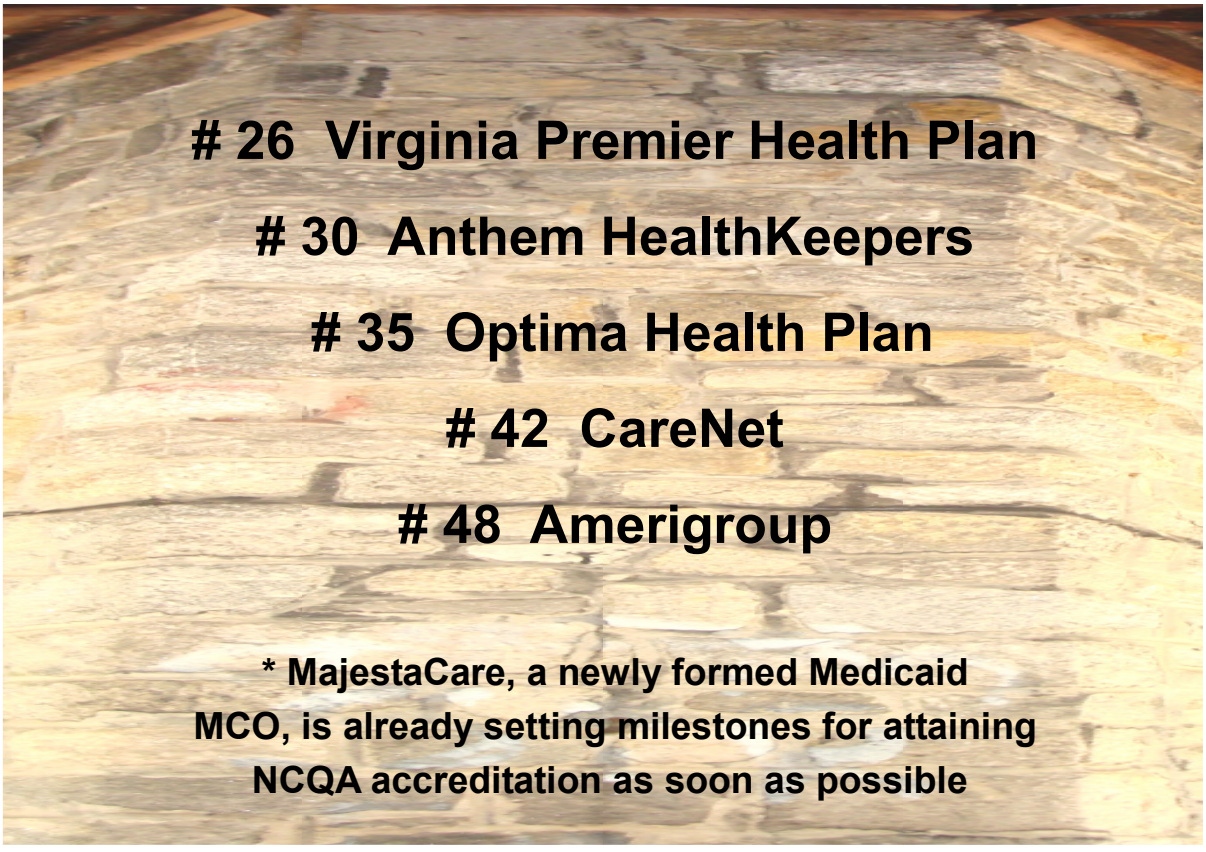
NCQA's Health Insurance Plan Rankings for 2011—2012

Virginia Medicaid MCOs Make List of Top 50 *Nationally*

Congratulations

Each year, the National Committee for Quality Assurance (NCQA) works in partnership with the Consumers Union of America to publish the NCQA's Health Insurance Plan Rankings. Three lists are published, one each for Medicaid, Medicare, and Commercial plans. The rankings are based on each MCO's performance, including consumer satisfaction, prevention, and treatment. This year, all Virginia Medicaid MCOs were in the top 50.*

Making the list of the top 50 is no easy feat, in fact a total of 99 Medicaid managed care plans received a ranking; with an additional 29 providing "insufficient data" - no ranking; and, finally another 85 Medicaid MCOs that provided no data, which also resulted in no ranking. These counts amount to a grand total of 213 Medicaid MCOs that were listed by NCQA. Similar to most rankings, 1 is the most favorable, and 99 is the lowest. Congratulations to our Medicaid MCOs on their rankings and for serving our populations so well.



The managed care quality collaborative selects one HEDIS measure per MCO for presentation at the DMAS annual best practice session. The selection stems from the MCOs' outstanding HEDIS scores. The following describes each MCO's best practice presentation conducted in January 2011*

Amerigroup

One Comprehensive Well-Child Visit Per Year for Ages 3, 4, 5, & 6 Yrs

The HEDIS 2010 rate for Amerigroup was 77% - up from 72% the previous year. The MCO attributes the increase to monthly data analysis, member outreach, and updates to primary care physicians on their patients who are over-due for a comprehensive well-child visit.

Anthem

Six Comprehensive Well-Child Visits between Birth and 15 Months of Age

The HEDIS 2010 rate for Anthem was 66% - up from 56% the previous year. The MCO attributes the increase to its multi-faceted approach, which included a public transportation (bus) campaign in English and Spanish; additional member education strategies; and, its physician pay-for-performance program.

CareNet

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (COPD-E)

HEDIS scores for pharmacotherapy management of COPD-E improved from 2009 to 2010 for both systemic corticosteroids (54% to 74%) and bronchodilators (62% to 84%). The MCO attributes the increases to its case management program, which matches interventions based on member-risk for complications.

Optima Health Plan

Follow-Up After Hospitalization for Mental Illness

HEDIS scores for follow-up increased from 2009 to 2010 for both 7 and 30 days—54% to 62% and 73% to 78%, respectively. The MCO attributes the increases to its program whereby hospitalized members at certain facilities are seen by a licensed behavioral health clinician during the inpatient stay and on discharge.

Virginia Premier Health Plan

Antidepressant Medication Management

HEDIS scores for antidepressant medication management increased from 2009 to 2010 for both the acute phase (49% to 65%) and continuation phase (35% to 51%). The MCO attributes the increases to their analysis of pharmacy data which is provided to the behavioral health to help guide the outreach to members.

*Numbers have been rounded by DMAS for convenience

Medicaid Managed Care

About 3 of every 4 Virginians with Medicaid will be served through a managed care organization

Adolescent Health will be a focus of the MCO-DMAS quality collaborative

New-to-Virginia Medicaid MCOs will be required by DMAS to attain specific milestones leading up to NCQA accreditation

Assurances for program integrity and protection from fraud and abuse will be implemented

Patient-centered medical home model will become more feasible with support from providers, purchasers, and payers

Member satisfaction with managed care will become even more transparent

More children will be smiling as a result of increased enrollment and use of preventive dental care

Focused study on behavioral health will be published and serve as a needs assessment for policy and program planners

Consumer choice when selecting a managed care plan will increase

Better health and health care for the Medicaid population that transitions from fee-for-service to managed care

Want to Know More?

Virginia Department of Medical Assistance Services
Commonwealth of Virginia
Division of Health Care Services
600 East Broad Street
Richmond, Virginia 23219

All photos were taken around the James River Park System and surrounding areas, Richmond, Virginia.

Published November 2011